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## **Operating Room Comments** *(Not Related to Petitions)*

- Letter from Donnie C. Lambeth, NC Baptist Hospital
  - Letter signed by following:
    - W. Stan Taylor, Wake Medical Center
    - Rebekah Swain, Rex Hospital
    - Duncan Yaggy, Duke University Hospital
    - Barbara Freedy, Novant Health
    - Kelly Butler, Randolph Hospital
    - Molly M. Dickinson, High Point Regional Hospital
    - Amy Graham, FirstHealth of the Carolinas
    - Jennifer Houlihan, Wake Forest University Baptist Medical Center
    - Kristi Hubbard, New Hanover Regional Medical Center
    - Melissa K. Shearer, Moses Cone Health System
    - Dee Jay Zerman, UNC Hospitals
    -
  - Letter from Mike Vicario, North Carolina Hospital Association
  - Letter from W. Stan Taylor, Wake Medical Center
-



## Wake Forest University Baptist

Donny C. Lambeth  
Interim President  
Chief Operating Officer  
North Carolina Baptist Hospital

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August 2, 2007

Dr. Dan A. Myers, Chairman  
State Health Coordinating Council  
Division of Health Service Regulation  
2714 Mail Service Center  
Raleigh, NC 27699-214

DFS Health Planning  
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AUG 03 2007

Medical Facilities  
PLANNING SECTION

**RE: Comments – Billing Dataset Usage in Operating Room Need Methodology**

Dear Dr. Myers,

I would like to take this opportunity on behalf of Wake Forest University Baptist Medical Center (WFUBMC) to thank the OR workgroup members for their time and effort in developing recommendations to further refine the OR need methodologies. It is important for hospitals, physicians and other providers to work with the state in providing the most accurate and credible data in all areas to ensure that appropriate planning takes place to meet the healthcare needs of the citizens of North Carolina. Hospital representatives, along with physicians, have been active in workgroups related to the revision of the acute care bed, operating room, GI endoscopy procedure rooms, gamma knife, PET scanner, and MRI scanner need methodologies. However, for many reasons I believe that using patient-level, claims/billing data processed by Thomson/Solucient in place of hospital and ambulatory surgical facility (ASF)-reported aggregate data for the operating room need methodology is premature and further discussion needs to take place prior to adoption by the State Health Coordinating Council (SHCC).

Therefore, I am submitting comments concerning the proposed change to billing/claims data processed by Thomson/Solucient from hospital and ambulatory surgical facility-reported data for the need determination of operating rooms. My concerns are outlined in the following comments:

1. At a meeting hosted by the North Carolina Hospital Association on July 12, 2007, representatives from Thomson/Solucient expressed concern and a lack of confidence as to the appropriateness of their patient-level, claims/billing dataset in its present format for use in the operating room need methodology for the annual State Medical Facilities Plan (SMFP). It is also important to note that the current SMFP operating room need methodology is based on a count of *operating room cases* and the Thomson/Solucient dataset is based on a count of *surgical procedures*. Operating room cases and surgical procedures represent counts of two fundamentally different items and it cannot be assumed that the existing SMFP operating room need methodology can be applied to a surgical procedure count dataset and yield a valid operating room need determination. By design, the proposal to convert to a surgical procedure dataset must also trigger an examination of the current operating room need methodology which is based on an operating room case count.

I believe that the expressed concern by Thomson/Solucient is related to the following issues:

- The UB-92 form, which hospitals have used since the early 1990s, has been eliminated and the new UB-04 form is now utilized. The Centers for Medicare & Medicaid Services expect a learning curve for the new form and the possibility of incorrect filings.

*North Carolina Baptist Hospital*

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- The SMFP currently utilizes patient-level, billing/claims data processed by Thomson/Solucient for its acute care bed need methodology, but an acute care bed day can only occur in an acute care bed. However, procedures billed using the UB-04 form can occur in many locations of the Hospital; including operating rooms, procedure rooms, special procedure rooms, GI endoscopy procedure rooms, treatment rooms, Emergency Department exam rooms, inpatient rooms, cardiac catheterization rooms, and dedicated angiography rooms. The UB form does not permit for the identification of where a procedure was performed or even if the procedure requires an operating room. In fact, the current NCHA/Thomson ambulatory surgery database includes many procedures that do not require use of an operating room, such as sutures, cardiac catheterization and insertion of a catheter.

Some OR workgroup members made it clear that they were more concerned with knowing **what** procedures were performed in hospitals and ambulatory surgery centers, as opposed to **where** the procedures were performed in them. The intent for usage of this billing/claims data needs clarification, as a methodology for determining need that is not based on utilization of the resource (operating room) itself is difficult to understand.

Furthermore, if the intent of the OR workgroup is to identify "all" procedures performed in a county to determine operating room need, then the Thomson/Solucient data fails to capture all procedures not performed in a hospital, including physician offices, plastic surgery centers, dentist offices, etc. Until this issue alone is more fully addressed, I believe it would be premature to consider using the Thomson/Solucient data in the operating room need methodology. Focusing on the type of procedures performed in hospitals and ASFs suggests a possible expansion of the scope of CON regulation, which would seem to be beyond the initial charge of the OR workgroup as articulated by Dr. Myers during the first quarter of 2007.

2. It has been stated several times by OR workgroup members that billing/claims data is "more accurate because hospitals are less likely to err on billing statements." In fact, hospitals make every attempt to be accurate on all reported utilization data, which includes billing/claims statements, as well as the Hospital License Renewal Application (HLRA).
3. Whether ICD-9-CM or CPT, procedure codes are dynamic and will require constant review and updating to ensure accuracy. As an example, the 1999 HLRA included eight (8) cardiac catheterization codes and three (3) electrophysiology codes, as compared to the 2007 HLRA which included thirteen (13) cardiac catheterization codes and thirty-one (31) electrophysiology codes. The Centers for Medicare & Medicaid Services' Hospital Inpatient and Ambulatory Surgery Center procedure lists include over 4,100 CPT procedure codes, as compared to the over 3,500 ICD-9-CM procedure codes.
4. There is a necessary lag from the time data is reported until it is incorporated in the need methodologies in the SMFP. Therefore, the operating room methodology for the 2010 SMFP will utilize data submitted beginning with Federal Fiscal Year 2008, which begins October 1, 2007 (in just two (2) months). It is my belief that hospitals, ambulatory surgery centers and Thomson/Solucient are not prepared to use billing/claim data submitted in this short timeframe for a new need methodology. There are too many questions that need to be answered before a complete, accurate patient-level database using billing/claim data processed by Thomson/Solucient can be available for use in the operating room methodology.

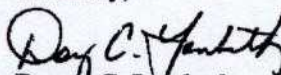
5. The current operating room need methodology uses hospital and ASF reported operating room **cases**, as opposed to **procedures**. The expansion of billing/claim data collection for procedures performed outside of operating rooms suggests a broadening of the scope of **what** is CON-regulated, and it is not clear that this was within the charge of the OR workgroup. No discussion has occurred as to how the operating room need methodology will be changed to use surgical procedures rather than surgical cases in determining operating room need. That may need to be the subject of an additional workgroup, even though the SMFP operating room need methodology was significantly revised and updated in the 2004 SMFP.

I believe that before the current SMFP operating room need methodology is significantly revised, that several variables should be considered for update:

- Examine and update the definitions of inpatient and outpatient operating room capacity.
- Better understand and analyze the minutes per operating room case information the licensed operating room providers have annually submitted since 2004 to the Division of Health Service Regulation.
- Update the standard hours per operating room per year, if this remains an element of the SMFP operating room need methodology.

In conclusion, WFUBMC welcomes the prospect of revising the current operating room need methodology, but we are concerned with the integrity of the surgical data. We prefer the data be accurate, whether it is hospital or ASF-reported aggregate data or patient-level data processed by Thomson/Solucient, and desire a thoroughly discussed need methodology. At a minimum, these discussions should address the issues raised in my comments to assure the appropriateness of any revised operating room need methodology data. Thank you for the opportunity to voice my concerns through these comments.

Sincerely,



Donny C. Lambeth  
Interim President/COO

1 August 2007

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AUG 03 2007

MEDICAL FACILITIES  
PLANNING SECTION

Dr. Dan A. Myers, Chairman  
State Health Coordinating Council  
Division of Health Service Regulation  
2714 Mail Service Center  
Raleigh, NC 27699-214

RE: Comments – Billing Dataset Usage in Operating Room Need Methodology

Dear Dr. Myers,

We would like to take this opportunity to thank the OR Workgroup members for all their time and effort in developing recommendations to further refine the OR need methodology. It is important for hospitals, physicians and other providers to work with the State to provide the most accurate and credible data in all areas to ensure that appropriate planning takes place and that the healthcare needs of the citizens of North Carolina are met. Hospitals have worked closely with the Division of Health Service Regulation throughout the planning and implementation process to make transitions to new datasets and need methodologies as smooth as possible. We have been active in workgroups related to the revision of the acute care bed, operating room, GI endoscopy procedure room, gamma knife, PET scanner, and MRI scanner need methodologies. Based on this experience, we believe that using patient-level, claims/billing data processed by Thomson/Solucient in place of hospital and ambulatory surgical facility (ASF)-reported aggregate data for the operating room need methodology is premature and needs to be discussed at greater length before it is adopted by the SHCC.

Therefore, the undersigned planning staff from hospitals throughout North Carolina are submitting these comments concerning the proposed change to using billing/claims data processed by Thomson/Solucient for the need determination of operating rooms. The undersigned represent community, referral, tertiary, and teaching hospitals that range in size from 145 beds to over 800 beds and from 6 operating rooms to over 40 operating rooms. These hospitals represent a cross-section of the 115 hospitals operating in North Carolina.

Our concerns are detailed in the following comments:

First, at a meeting hosted by the North Carolina Hospital Association on July 12<sup>th</sup>, 2007 representatives from Thomson/Solucient expressed concern and a lack of confidence as to the appropriateness of their patient-level, claims/billing dataset in its present format for use in the operating room need methodology for the annual State Medical Facilities Plan (SMFP).

We believe that the expressed concern by Thomson/Solucient is related to the following issues:

- The UB-92 form, which hospitals have used since the early 1990s, has been eliminated and the new UB-04 form is now utilized. The Centers for Medicare & Medicaid Services expect a learning curve for the new form and the possibility of incorrect filings.

For example, even the Healthcare Cost and Utilization Project, which is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ) raised concerns that billing data from UB forms may not always be accurate.

- The current range of codes that are required to be reported to the Thomson/Solucient database include procedures that can occur in many locations in the hospital; including operating rooms, procedure rooms, special procedure rooms, GI endoscopy procedure rooms, treatment rooms, Emergency Department exam rooms, inpatient rooms, cardiac catheterization rooms, and dedicated angiography rooms. The UB form does not identify where a procedure was performed or if the procedure requires an operating room. In fact, the current Thomson/Solucient ambulatory surgery database includes many procedures that do not require use of an operating room, such as sutures, cardiac catheterization and insertion of a urinary catheter.

Some Operating Room Workgroup members made it clear that they were concerned with knowing **what** procedures were performed in hospitals and ambulatory surgery centers, as opposed to **where** the procedures were performed in them. While the Thomson/Solucient database would be more likely to accomplish this count of defined procedures, it is unclear how it will be determined which procedures will be included and what methodology will be used for calculating operating room need from this procedure count data. We believe that until this issue is addressed more fully that it would be premature to consider using the Thomson/Solucient data in the operating room need methodology

Furthermore, if the intent of the Operating Room Workgroup is to identify "all" procedures performed in a service area in order to determine operating room need, then the Thomson/Solucient is not sufficient. This database fails to capture procedures performed in physician offices, plastic surgery centers, dentist offices, etc. Focusing on the count of procedures performed in multiple locations

suggests a possible expansion of the scope of CON regulation, which would seem to be beyond the initial charge of the Operating Room Workgroup as you articulated it during the first quarter of 2007.

- The Thomson/Solucient database is in a period of transition from reporting primarily in terms of ICD-9 procedure codes to using CPT procedure codes. While the impact of this change is not yet completely understood, two things are evident. The range of CPT codes that are required to be reported is broader than that of ICD-9, and as hospitals move to CPT reporting, we can expect the dataset to triple in size. In addition, the CPT-based reporting will not include a primary procedure, making it much more difficult to classify types of procedures or define a set of cases by procedure code.

Second, it has been opined several times by Operating Room Workgroup members that billing/claims data is "more accurate because hospitals are less likely to err on billing statements." In fact, hospitals make every attempt to be accurate on all reported utilization data, which includes billing/claims statements, as well as the Hospital License Renewal Application (HLRA). After the second Operating Room Workgroup meeting it became obvious that data reported on both the HLRA and the ASF License Renewal Application can be inaccurate. However, inaccuracies on the HLRA and ASF LRA are more likely due to lack of clear instructions and definitions on the LRA's. For example, even Workgroup members were confused by a question regarding "Same Day Surgery Cases" (2007 HLRA, page 5), as compared to the definition of "Ambulatory Cases" (2007 HLRA, pages 8 and 9). We believe that changes to the HLRA could improve the integrity of the data, and we welcome the opportunity to submit this data electronically, where automatic accuracy reviews can be instantly incorporated.

Third, whether ICD-9-CM or CPT, procedure codes continue to be created and eliminated as new techniques are developed. Any list of codes used in the OR methodology will require constant review and updating to ensure accuracy. As an example, the 1999 HLRA included eight (8) cardiac catheterization codes and three (3) electrophysiology codes, as compared to the 2007 HLRA which included thirteen (13) cardiac catheterization codes and thirty-one (31) electrophysiology codes. In fact, the Centers for Medicare & Medicaid Services' Hospital Inpatient and Ambulatory Surgery Center procedure lists include over 4,100 CPT procedure codes, as compared to the over 3,500 ICD-9-CM procedure codes.

Fourth, there is a necessary lag from the time data is reported until it is incorporated in the need methodologies in the SMFP. The workgroup has recommended that a new dataset be used for the 2010

SMFP. That will require using data submitted beginning with Federal Fiscal Year 2008, which begins October 1, 2007, just two (2) months from now. It is our belief that hospitals, ambulatory surgery centers, and Thomson/Solucient are not prepared to use billing/claims data submitted in two months time for a new need methodology. There are too many questions that need to be answered before a complete, accurate patient-level database using billing/claims data processed by Thomson/Solucient can be available for use in the operating room methodology.

We ask that the SHCC delay the recommendation to change the data source for the OR methodology in the SMFP. As we have outlined in this document, there are many issues that need to be addressed before the data collection can occur, and we do not believe these issues can be addressed in the next sixty days. We believe that several variables from the existing methodology should be considered for more immediate adoption by the SHCC to improve the OR need methodology:

- Examine and update the definitions of inpatient and outpatient operating room capacity to better reflect actual availability
- Better understand and analyze the minutes per operating room case information that the licensed operating room providers have annually submitted since 2004 to the Division of Health Service Regulation
- Update the Standard Hours Per Operating Room per Year

In conclusion, we want to emphasize that we welcome the revision of the current operating room need methodology, but we are concerned with the appropriate usage of the Thomson/Solucient billing/claims database. We want data used in the SMFP to be accurate, whether it is hospital or ASF-reported aggregate data or patient-level data processed by Thomson/Solucient, and want a thoroughly discussed need methodology, even one that may evolve over time. At a minimum, these discussions should address the issues raised in our comments to assure the appropriateness of any revised operating room need methodology data.

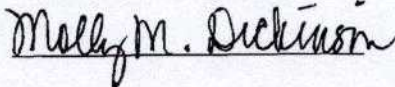
Thank you for the opportunity to voice our concerns through these comments.

Sincerely,

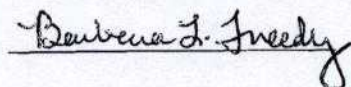
Kelly Butler  
Planning Director  
Randolph Hospital



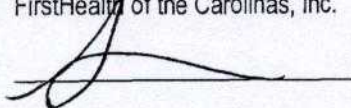
Molly M. Dickinson  
Director of Planning  
High Point Regional Health System



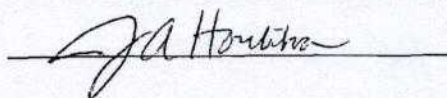
Barb Freedy  
Novant Health, Inc.  
Financial Planning and Analysis--Certificate of Need - Director



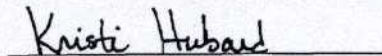
Amy Graham  
Director, Business Development  
FirstHealth of the Carolinas, Inc.



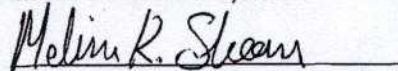
Jennifer Houlihan  
Manager, Government Relations & Regulatory Affairs  
Wake Forest University Baptist Medical Center



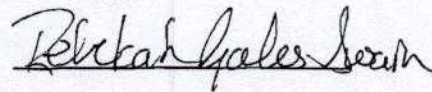
Kristi Hubard  
Director, Business Analysis and Planning  
New Hanover Regional Medical Center



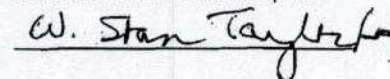
Melissa K. Shearer  
Planning Associate  
Corporate Planning and Development  
Moses Cone Health System



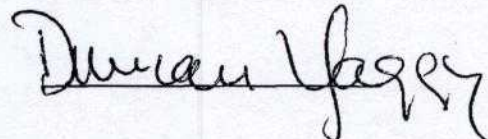
Rebekah Swain  
Director, Strategic Planning  
Rex Healthcare



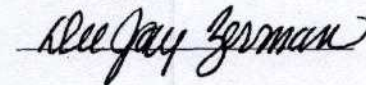
W. Stan Taylor  
Vice President  
Corporate Planning & Managed Care  
WakeMed Health and Hospitals



Duncan Yaggy  
Chief Planning Officer  
Duke University Health System



Dee Jay Zerman  
Associate Director of Planning  
UNC Hospitals



August 3, 2007

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Medical Facilities  
PLANNING SECTION

Dr. Dan A. Myers, Chairman  
State Health Coordinating Council  
Division of Health Service Regulation  
2714 Mail Service Center  
Raleigh, NC 27699-2714

Dear Dr. Myers:

On behalf of WakeMed, I would like to take this opportunity to provide comments regarding the recent recommendations from the Operating Room Methodology Work Group. We appreciate all the hard work that the Work Group has done in analyzing the issues and in developing its recommendations; however, we have ongoing concerns regarding Recommendations 3A and 5.

Regarding Recommendation 3A – "Uniform Procedure Count," WakeMed recognizes the need for accurate data; however, it believes that there are too many issues with the billing data for it to provide the level of accuracy required by the State. Billing data is coded and designed to meet payor requirements for reimbursement. By its very nature, it is not designed to meet planning needs. Indeed, at a recent meeting of hospital planners and state representatives, a Thomson representative agreed that the data was not suited for this purpose. For example:

- There is no reliable way to determine where a procedure was performed. Some minor procedures may be performed in an emergency department treatment room or in a minor procedure room, as opposed to an operating room. Although it has been suggested that revenue codes can provide that level of detail, for some CPT codes, the revenue codes are automatically assigned, regardless of where the procedure is performed.
- Claims data are dynamic; i.e., coding may be changed based on subsequent review of patient care or based on payor requirements. For example, patient status may be changed from inpatient to outpatient, or vice versa. If the Thomson data are submitted and the claim is later changed, that will affect the accuracy of the data. Given that inpatient procedures are allotted 180 minutes in the OR methodology as opposed to 90 minutes for outpatient procedures, this could have an impact on the outcome of the methodology. Also, claims that are in pending status at the time of data submission may never be submitted.
- In some instances, e.g., if a patient qualifies for charity care or for a full write-off of charges, a claim may not be generated for that patient. Therefore, the final count will be understated. This could have a greater impact on facilities which provide higher levels of charity care, such as WakeMed.

Based on discussions held in recent meetings at the North Carolina Hospital Association, it appears that there is still no consensus on the specific data that should be collected from hospitals, whether it should be all surgical procedures, regardless of where they are performed; specific cases based on designated CPT or ICD codes; or whether it should be only those cases that are performed in surgical operating rooms. It is important that this be determined before the OR methodology is modified. For example, should hospitals be required to report all

surgical cases, regardless of where they are performed, the OR methodology will need to incorporate minor procedure rooms. Otherwise, the case count will be inflated and will likely generate a significant need for additional operating rooms, because the OR inventory (included in the formula denominator) will not include minor procedure rooms, but the corresponding procedures will be included in the formula numerator.

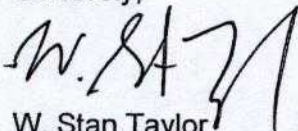
WakeMed also believes that it will be difficult to implement Recommendation 5 "Convene a panel of experts to determine which ICD and CPT procedure codes should be included when planning for operating room capacity". As shown in The Dartmouth Atlas of Health Care, physician practice patterns vary significantly in different regions of the country based on where the physician was trained, local standards of care, etc. Similarly, WakeMed believes that there is likely significant variation across the State regarding how and where procedures are performed, and that it will be difficult and expensive to reach consensus. For example, some procedures may routinely be performed laparoscopically on an outpatient basis in urban areas; however, for the same diagnosis in a rural area, a surgeon may still perform open procedures and subsequently admit the patient. It may also be difficult to find physicians willing to donate their time to work on this project, given that there are over 1,000 ICD procedure codes.

WakeMed submits these suggestions for consideration:

- Specifics regarding the data to be collected need to be resolved. Based on that decision, corresponding adjustments should be made to the OR inventory and OR methodology.
- The State should continue its efforts to work with hospitals to ensure that the data submitted on licensure applications are accurate. Holding educational sessions would promote accuracy and consistency among NC hospitals.
- Alternative sources of data that have not yet been considered may meet the State's needs, such as electronic OR logs.

WakeMed recognizes that this is a complicated issue that will not be easy to resolve. However, we believe that at this time, using claims data for this purpose is not feasible. We appreciate this opportunity to submit comments and we look forward to continuing to work with the State on this project.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Stan Taylor". The signature is stylized with a large, sweeping "W" and a long, horizontal stroke extending to the right.

W. Stan Taylor  
Vice President, Corporate Planning and Managed Care



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North Carolina Hospital Association

August 3, 2007

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Medical Facilities Planning Section  
Division of Health Service Regulation  
2714 Mail Service Center  
Raleigh, NC 27699-2714

AUG 03 2007

Medical Facilities  
Planning Section

Dear Ms. McClanahan and Members of the State Health Coordinating Council:

The State Health Coordinating Council (SHCC) has received and approved several recommendations from the Operating Room Need Methodology Workgroup. Recommendations 3A and 3B pertain to data sources used for the methodology, and Recommendation 5 includes a process to establish which procedures should be reported.

For the reasons listed below, NCHA recommends that the SHCC consider establishing a new target year beyond the 2010 SMFP (using 2008 data) for applying these data to the methodology. The data should be reviewed, along with the licensure data, until the SHCC is satisfied that reporting issues have been addressed and that the two sources of data are consistent within a reasonable threshold.

In consultation with its member hospitals and the state's certified data processor, Thomson Healthcare, NCHA makes the following observations related to the Workgroup's recommendations.

*Recommendation 3B - License Renewal Application: Improve the License Renewal Application Data to make it more accurate and verifiable by revising terminology, clarifying definitions, and providing instruction and guidance regarding key data elements. Focus specifically on improving the reporting of average resource hours, inpatient case time, outpatient case time, and number of inpatient and outpatient cases. Consider the feasibility of electronic data reporting.*

NCHA hospitals met with representatives from the Division of Health Service Regulation (DHSR) during the summer. Hospitals provided recommendations to address the concerns of the workgroup by clarifying, updating and revising the form, with special attention to the need for improved instructions and definitions. Even a methodology that relies on verifiable billing data to count surgeries will require an accurate licensure form to gather other data such as surgical hours and operating room counts.

NCHA believes the adoption of an electronic licensure reporting process is needed and would help to avoid inaccuracies as well as transcription and mathematical errors that can occur with the current licensure reporting form.

*Recommendation 3A - "Uniform Procedure Count": Recommend the SHCC adopt utilization of accurate verifiable billing data to count the number of procedures that require the use of an operating room, in both inpatient and outpatient surgical facilities.*

NCHA is continuing its research of the issues involved in using the Patient Data System ambulatory procedure database (*administered by Thomson Healthcare - the state certified data processor*), to count procedures that require the use of an operating room. We have met with hospitals, DHSR, Thomson Healthcare and others, and have reviewed policy and payment changes at federal and state levels. We believe that there are significant changes that are already affecting the reporting of ambulatory procedures and that should be considered before implementing a process of using next years (October 2007 - September 2008) PDS ambulatory procedure data for the 2010 SMFP.

- In spring of this year NCHA learned of a new requirement from two major payers (Medicare and Blue Cross/Shield) that hospitals submit claims using CPT codes rather than the ICD-9 codes that hospitals were previously required to use. This follows a HIPAA Transactions and Code Sets Rule requirement and is expected to impact all North Carolina hospitals and eventually all payers as they move to require CPT codes for ambulatory procedures. Hospitals that choose to *report* data to Thomson using CPT codes are expected to lose some comparability with their ICD-9 coded inpatient procedures, so there may be reluctance among some to report using CPT codes. Further, hospitals will typically be unable to report CPT codes without changes to their internal information systems, changes required by their clearinghouses, and / or their system vendors.

- Two hospital members that were preparing to submit CPT coded data reports subsequently found large increases in their procedure counts, some of which were determined to be caused by procedures that were included in the state's CPT range but not in the ICD-9 range. (*The code ranges that were used by the Medical Database Commission are still used.*) The incomparability among the code ranges for the two systems is expected to result in significant discrepancies in reported codes, resulting in major procedure count differences from prior years, according to several hospitals' own internal analyses. This will need to be resolved before the PDS can be successfully used for state planning.

- Inpatient surgery billings include any outpatient procedures performed within 72 hours of an inpatient surgery, so any additional surgery related data within this timeframe would not be captured.

- Other billing changes are also in the transition process. The UB-92 billing manual has just been replaced with the UB-04 manual, introducing changes to payer codes. HHS is in the process of transitioning hospitals to their own NPI (National Provider Identifier) codes, which are different from Medicare provider numbers and apply differently to each part of an institution. HHS is also in the process of transitioning from UPIN (Unique Physician Identification Number) codes to NPI codes for physicians. HHS is also changing diagnoses codes to a present-on-admission indicator, for which alone HHS has indicated it expects a two-year learning curve and the possibility of incorrect filings. This represents yet another dynamic that potentially complicates use of the ambulatory surgery data for planning purposes.

*Recommendation 5 - Panel of experts: Recommend DFS convene a panel of experts to determine which ICD and CPT procedure codes should be included when planning for operating room capacity. This list would be used with the "Uniform Billing" data to ensure the same procedures are counted in each facility regardless of where the procedures are performed.*

- Thomson Healthcare and some on the workgroup have noted that ambulatory billing data does not include the site of a surgical service or denote whether an operating room was used. While a "panel of experts" may be able to establish which procedure codes should require the use of an operating room and be used to plan for total operating room capacity; it will not be possible to use PDS data to determine how

many surgeries were performed in existing operating rooms for any prior year. Only the licensure forms provide this information.

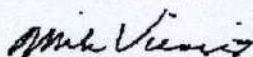
- Thomson Healthcare has indicated that while it would eventually like to see the outpatient database used for state planning purposes, there is less consistency—that is, greater variation—in payers' requirements for sending data for payment of outpatient claims as compared with inpatient claims. The outpatient billing process is more complicated and less standardized than the inpatient billing process. Given the number of transitional issues and changing payer requirements occurring over the next two years, the use of outpatient billing data beginning in FY 2008 would result in variations between the licensure data and billing data that would be very difficult to resolve. Attempting a reconciliation of the two data sources would impose significant burdens on hospitals.

NCHA assists hospitals with billing related issues and is aware, through regular meetings and discussions with payers and hospitals, of a number of billing logic issues that could affect outpatient claims and volumes. In addition, there are many billing and information systems, each with limited, differing capabilities in hospitals from which data are extracted for reporting to Thomson. Hospitals use system software vendors, claims clearinghouses, and in-house IT staff, alone or in combination, to derive data files for Thomson. In the process of billing, a clearinghouse may require different coding than the hospital submits, and may change the coding to meet its own requirements. So the hospital's internal system may not contain the coding that was ultimately required for transmission of a claim to a payer, and justifying the internal system to what Thomson receives may not be possible for reasons beyond the control of the hospital.

NCHA supports using the most accurate data available for the operating room methodology. However, the issues pertaining to coding, regulations, reimbursement and technology are changing rapidly and could not have been incorporated into the workgroup recommendations with any level of detail. Many of these challenges were not fully described or known at the time the workgroup made its recommendations. We request that the SHCC consider these factors in its work to establish an accurate and verifiable methodology for operating rooms.

Thank you for your continued work in improving the health planning process, and please let us know how we can assist. Please feel free to contact me if you have questions.

Sincerely,



Mike Vicario  
Vice-President of Regulatory Affairs